ARKANSAS REGISTER

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date _____ Code Number _____

Name of Agency: Arkansas Department of Human Services

Department: Division of County Operations

Contact Person: Linda Greer Phone: 682-8257

Statutory Authority for Promulgating Rules: AR Code Annotated 20-76-201 et. Seq. & AR Code Annotated 20-15-201 et. Seq.

MS 26200, Assisted Living Facilities Waiver

		Date
Intended Effective Date	Legal Notice Published	Sept. 26 - Oct. 3, 2002
☐ Emergency	Final Date for Public Comment	October 25, 2002
☐ 10 Days After Filing	Filed With Legislative Council	
☒ Other	Reviewed by Legislative Council	
January 1, 2003	Adopted by State Agency	January 1, 2003

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

_____
Signature

Director, Division of County Operations

_____
Title

_____
Date

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION of County Operations
DIVISION DIRECTOR Joni Jones, Director
CONTACT PERSON Linda Greer, Acting Assistant Director, OPPD

ADDRESS P. O. Box 1437, Slot S-332, Little Rock, AR 72203
PHONE NO. 682- 8257 **FAX NO.** 682-1597

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

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1. **What is the short title of this rule?**
Medical Services Policy MS 26200 - 26255, Assisted Living Facilities Waiver.

2. **What is the subject of the proposed rule?**
The proposed rule provides Assisted Living Services in a residential setting to aged, blind and disabled individuals 21 years of age and over, allowing them to maintain independence and dignity while receiving a high level of care and support.

3. **Is this rule required to comply with federal statute or regulations? Yes___No_X**
If yes, please provide the federal regulation and/or statute citation.

4. **Was this rule filed under the emergency provisions of the Administrative Procedure Act?**
Yes__ No_X

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire?

Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? Yes__ No

5. **Is this a new rule? Yes X No ____**

Does this repeal an existing rule? Yes ___ No X
If yes, please provide a copy of the repealed rule.

Is this an amendment to an existing rule? Yes ___ No X If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

6. **What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.**

AR Code Annotated 20-76-201 et. Seq., AR Code Annotated 20-15-201 et. Seq., & Title XIX Waiver for Home and Community-Based Services under Section 1915(c) of the Social Security Act.

7. **What is the purpose of this proposed rule? Why is it necessary?**
To provide Medicaid coverage for individuals in Assisted Living Facilities..

8. **Will a public hearing be held on this proposed rule?**
Yes __ No X If yes, please give the date, time, and place of the public hearing?

9. **When does the public comment period expire?**

10. **What is the proposed effective date of this proposed rule?**
December 1, 2002.

11. **Do you expect this rule to be controversial? Yes**
No X If yes, please explain.

12. **Please give the names of persons, groups, or organizations which you expect to comment on these rules? Please provide their position (for or against) if known.**

None known.

PLEASE ANSWER ALL QUESTIONS COMPLETELY

July 28, 1995

DEPARTMENT Department of Human Services
DIVISION Division of County Operations
PERSON COMPLETING THIS STATEMENT Linda Greer
TELEPHONE NO. 682-8257 **FAX NO.** 682-1597

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE: Medical Services Policy MS 26200 - 26255, Assisted Living Facilities Waiver.

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?**
   Yes X **No**

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**

   Not Applicable

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.**

2002 Fiscal Year		**2003 Fiscal Year**	
General Revenue	$	**General Revenue**	$
Federal Funds	$	**Federal Funds**	
Cash Funds		**Cash Funds**	
Special Revenue		**Special Revenue**	
Other		**Other**	
Savings Total		**Savings Total**	

4. **What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?**

2002 Fiscal Year	**2003 Fiscal Year**

5. **What is the total estimated cost by fiscal year to the agency to implement this regulation?**

2002 Fiscal Year		**2003 Fiscal Year**	
Total	$1,676,640	Total	$3,307,314
Federal Share	1,238,534	Federal Share	2,443,113
State Share	438,106	State Share	864,201

July 28, 1995

NOTICE OF RULE MAKING

Pursuant to Arkansas Code 20-76-201 et Seq., effective December 1, 2002, Medicaid will begin providing coverage for aged, blind or disabled individuals under the Assisted Living Facilities Waiver program.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-333, Little Rock, AR 72203. All comments must be submitted in writing to the above address no later than _____.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to age, religion, disability, political affiliation, veteran status, age, race, color or national origin.

_____

Joni Jones,
Director, Division of County Operations

Date:_____

26200 ASSISTED LIVING FACILITIES 01-01-03

Medicaid for individuals in Assisted Living Facilities (ALF) was established by the approval of a Title XIX Waiver for Home and Community-Based Services under Section 1915(c) of the Social Security Act. The purpose of the waiver is to provide Assisted Living Services in a residential setting to aged, blind and disabled individuals 21 years of age and over, allowing them to maintain their independence and dignity while receiving a high level of care and support. Arkansas authorized coverage of this group effective January 1, 2003..

The Division of Aging and Adult Services (DAAS) has administrative responsibility for the Assisted Living Waiver program. A limited number of slots have been requested for the Assisted Living Waiver for the first three years of the program. For year one, 275 slots have been requested, for year two, 335 slots, and for year three, 395. Availability of additional slots will depend on continued financing for the program. If the cap is reached, further instructions will be issued regarding how a statewide waiting list will be administered.

Assisted living facilities must provide living units and common space and assure that services are provided to address all activities of daily living on a 24-hour basis. Room and board costs are not included in the waiver coverage. Payments for waiver services are intended to reimburse the provider for costs associated with providing services to residents. Provider staff will assist with the provision of such services as:

- Activities of Daily Living (ADL) Care, i.e., eating/nutrition, dressing, bathing/personal hygiene, mobility, bowel and bladder, and behavior.

- Independent Activities of Daily Living (IADL) Care, i.e. medication management, transportation, meal preparation, shopping, laundry and housecleaning.

Access to certain tasks must be available on a 24-hour basis. Recipients of ALF waiver services will also be eligible for the full range of Medicaid benefits with the exception of Medicaid State Plan personal care services.

26205 Eligibility Requirements 01-01-03

Eligibility for Assisted Living Facility Medicaid is based on the Medicaid policy for Long Term Care (Re. MS 3000 Section). To be eligible for the program an individual must meet both non-medical and medical criteria.

I. Non-Medical Criteria

A. Income - The individual's gross income cannot exceed the current LTC income limit, or three times the SSI standard payment amount. (See SSI Chart at Appendix S for current amounts.) However, individuals with income over

the LTC limit may be eligible if they establish an income trust (Re. MS 3336.9).

B. Resources - Total countable resources cannot exceed the current LTC limitations. Resources are determined and verified according to LTC guidelines (Re. MS 3330).

   The spousal impoverishment policy (Re. MS 3337 - 3338.12) for income and resources will apply to ALF Medicaid.

   The transfer of resource provisions will apply. If assets have been transferred during the look back period, a period of ineligibility for waiver services will be imposed for uncompensated value. As an individual must receive waiver services to qualify for Medicaid in the Assisted Living Facility category, penalty would be imposed on regular Medicaid services as well as waiver Medicaid services.

C. Citizenship - The individual must be a citizen of the United States or a Qualified Alien (Re. MS 3310 #3 and MS 3324).

D. Residency - The individual must be a resident of Arkansas (Re. MS 2200).

E. Social Security Enumeration - The individual must meet the Social Security Enumeration requirement (Re. MS 1390).

F. Cost Effectiveness - The cost of ALF services must be less than the cost of institutionalization. This determination will be made by DAAS.

G. ALF recipients must be either aged (age 65 or over), or 21 years of age or over and blind or disabled as established by SSI/SSA or by the Medical Review Team (per MS 3322 - 3323.3).

All eligibility requirements, with the exception of cost effectiveness, will be verified and documented at initial certification. It may be assumed by the DCO caseworker that an individual applying for the ALF program will meet the cost effectiveness criteria. If at any time DAAS determines that cost effectiveness is not met, the caseworker will be notified.

II. Medical Criteria

Intermediate Level of Care - Individuals must be classified as requiring an Intermediate Level of Care if in an institution, as determined by Utilization Review. Individuals classified as Skilled Care patients are not eligible for the ALF program. To be determined a functionally disabled individual, the

individual must meet at least one of the following three criteria as determined by a licensed medical professional:

A. The individual is unable to perform either of the following:

1. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or
2. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or,

B. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired, requiring substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

C. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening.

No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.

NOTE: If an individual requires a Skilled Level of Care, eligibility for ALF will be denied. Likewise, if an individual has a serious mental illness, except as specified in Section II above, or has mental retardation, the individual will not be eligible for ALF. However, the diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting the criteria outlined in Sections I or II above.

26210 Application Process 01-01-03

Applications for ALF Waiver will be made on the Application for Assistance, DCO-777, or the Request for Assistance (RFA), DCO-215, in the county DHS office where the facility is located. Applications can be made by the applicant, designated representative, next of kin, or person acting responsibly for the individual. If application is made in the applicant's home county before he/she enters the facility, and the applicant enters a

facility in another county, the application will be denied on the system. A DCO-700 will then be completed, advising the client or representative that the application has been sent to the appropriate county. All records will then be transferred to the county where the facility is located. A new application will not be needed by the receiving county, and the original date of application will be entered when the application is reregistered.

If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.

The caseworker will have a maximum of 45 days from the date of application, or 90 days if MRT is needed, to approve or deny the ALF application.

26212 Registering the ALF Application 01-01-03

In non-ANSWER counties, applications will be registered in Category 11, 41 or 31. ALF Waiver recipients having SSI will retain their SSI Category 13 or 43 numbers. "AL" will be keyed in the Waiver Field on WIMA when the application is registered. A code of "3000" will be keyed to the Nursing Home Number Field on WNHU when an ALF individual enters the facility from the community. A code of "3001" will be entered when the individual enters the program from a LTC facility. Separate applications will be registered when both members of a couple apply.

26215 Applications from Nursing Facilities or ElderChoices or AAPD Waiver Recipients 01-01-03

If the county is contacted regarding an ALF application for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, or an ElderChoices or AAPD Waiver recipient, the caseworker will notify the DHS nurse (via the DHS-3330). The DHS nurse will visit the client on site to begin the assessment process to develop a Plan of Care. The county will be notified of the recipient's election of ALF Waiver services. The signed election of ALF Waiver services will serve as the application for ALF, and a new DCO-777 or DCO-215 need not be completed by the applicant, unless it is time for the annual reevaluation of the LTC or Waiver case. The top portion of the DCO-777 must be completed and keyed to register the ALF application.

If a non-Medicaid eligible nursing facility resident wishes to apply for ALF Waiver, the DCO-777, Application for Assistance, or DCO-215, RFA, must be completed and registered. The caseworker will notify the DHS RN, who will initiate the assessment.

26220 Assessment Process 01-01-03

All applicants will be referred to the DHS RN within 2 days of the office interview for coordination of the medical assessment. An individual assessment of each prospective ALF recipient will be performed by the DHS Registered Nurse using the AAS-9703. The

RN will visit the client on site to evaluate his or her physical, functional, mental, emotional, and social status, as well as to obtain a medical history. The DHS RN will develop a Plan of Care based on the assessment and the AAS-9703. The plan must include the medical and other services to be provided, their frequency, and the type of provider to furnish the service. The client's choice of service provider must be specified by this time. The DHS RN will ensure that the applicant's degree of incapacity is reflected accurately.

Form AAS-9703 will be signed by the ALF applicant, the DHS RN, and the applicant's attending physician. The form will then be submitted for determination of nursing home level of care eligibility. The Decision for Nursing Home Placement Form, DHS-704, will be routed to the DHS RN and the county office.

If an individual meets the Intermediate Level of Care requirements, and if the individual is otherwise eligible, DAAS will work with the client, family, or other caregiver to ensure that the client receives the services necessary to meet his/her needs according to the written Plan of Care.

Waiver services will not be provided where the cost of home and community based care exceeds, on an annualized basis, the cost of Intermediate Level of Care for the recipient in a nursing facility.

The DHS RN is responsible for monitoring the status of ALF clients on a regular basis, checking for changes in their service needs, referring clients for reassessment if necessary, and reporting any client complaints of violations of rules and regulations to the appropriate authorities for investigation.

26225 Eligibility Determination 01-01-03

Eligibility determination for ALF Waiver cases will be conducted in the same manner as for AABD long term care cases.

The SSI related income and resource criteria located in the MSP 3000 section will be followed (SSI exclusions are not allowed from gross income in determining eligibility).

In determining an ALF applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income compared in his/her budget to the current LTC limit. (Re: Appendix S). For an applicant with an ineligible spouse, only the income of the applicant will be considered for eligibility.

An individual with income over the current LTC income limit may establish Medicaid/Waiver eligibility by establishing an Income Trust (Re: MS 3336.9).
In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one-person limit. When there is a married

couple, and only one member of the couple applies, the rules for spousal impoverishment (Re. MS 3337 - 3338.12) regarding income and resources will be applied.

26230 Contribution to the Cost of Care 01-01-03

ALF Waiver recipients are allowed to keep a flat 90.8% rounded up of the SSI/SPA for room and board. This will allow the individual to purchase food from the facility, or elsewhere, if they prefer. In addition to the charge for room and board, a monthly personal allowance will be deducted. The personal allowance will be based on 9% of the SSI/SPA and rounded up. Both will increase each January with the SSA/SSI Cost of Living Increases. See Appendix S for current amounts.

In addition to room and board and the personal allowance, the following expenses are to be deducted from the cost of care:

- Monthly medical insurance premiums for the ALF recipient
- Non covered medical expenses including over the counter medications and medical supplies for the ALF recipient
- Spousal support payments for the community spouse and Family Member Allowance
- Bank service charges on the Income Trust account
- Earnings up to the monthly SSI/SPA amount if employment is prescribed as therapeutic by the attending physician

The ALF recipient's income, minus room and board, personal allowance and certain other expenses, will be contributed to their cost of care each month.

26235 Approvals for New Applicants (Non-LTC) 01-01-03

After all eligibility criteria have been established, the effective date of ALF Waiver eligibility will be the day the individual's Plan of Care is signed by the applicant and the DHS RN. The DHS RN will provide the Waiver eligibility date to the county via the DMS-3330. Eligibility will not be established prior to the development of the Assisted Living Plan of Care by the DHS RN. Applicants who desire Medicaid coverage for the time before admission to the ALF, or before the Plan of Care is signed, must be determined in another category. The same application form can be used, but a separate application must be registered to determine coverage prior to eligibility for Assisted Living Facility Medicaid.

When certifying an eligible couple, each will be entered into the system using separate case numbers.

The gross income of the eligible individual will be entered in the appropriate fields in the system. The cost of room and board, as well as the spousal support amount, health insurance premium amount, bank service charges for the income trust account, and other

deductions, if applicable, will be entered as Protected Maintenance. The personal allowance will be shown in the PA field.

26240 **Approvals for Medicaid Recipients Who Leave LTC, ElderChoices or AAPD Waiver** **01-01-03**

If the county receives notice from the DHS RN that the LTC, ElderChoices or AAPD Waiver recipient has elected to enter an ALF and meets the Intermediate Level of Care, the ALF Waiver case can be approved once notice is received that the recipient has left the facility or the EC or AAPD program. A new DHS-704 will be required before the case can be certified, if the Intermediate Level of Care was entered by the county more than 6 months previously, or if the Level of Care Review Date has expired.

To certify the ALF Waiver case, close the LTC vendor payment or waiver portion of the case, but do NOT close Medicaid. The day after the LTC vendor, EC or AAPD portion of the case is closed, the ALF waiver portion of the case may be opened. To clear the pending application screen when approving NON-SSI recipients, counties will need to call the Systems and Reporting Unit (682-1530) for assistance in clearing the register as an approval.

When opening a case in which the Intermediate Level of Care was entered on the LTC vendor portion of the system less than six months previously, and there is no Level of Care review Date in the system, show the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility, with a Level of Care Review Date 12 months from the original level of care decision date.

If there is a future Level of Care Review Date when closing the LTC or Waiver case, use that level of care review date when opening the ALF case, again showing the Level of Care Decision Date and the Eligibility Begin Date as the first day of ALF eligibility. Caseworkers should review the records of recipients who leave LTC facilities or other Waiver programs for the ALF Waiver program. If it is time for the annual reevaluation, the reevaluation should be done prior to ALF certification.

NOTE: If a LTC case was closed, then reopened for ALF services and a retroactive adjustment must be made to the LTC case, send a memorandum to the Office of Long Term Care, MMIS Unit, Slot S406, P.O. Box 1437, Little Rock, 72203. The memorandum must include the name, case number, month(s) of retroactive change(s), and the new net income amount(s).

As the providers are different for each Waiver program, the caseworker must notify the DHS RN or Counselor any time that a Waiver recipient changes from one Waiver program to another, or when the case is closed or transferred.

26245 Reevaluations 01-01-03

ALF Waiver reevaluations will be conducted annually by the county office. Form DCO-777 or DCO-215 and all other forms required at initial application will be completed. After eligibility has been redetermined, the review date will be keyed to the system.

Reassessment of medical necessity will also be completed annually by DAAS.

26250 Changes/Closure 01-01-03

ALF Waiver recipients will be advised to report any changes in income or resources to the county DHS office.

If at any time DAAS determines that cost effectiveness is not met, or that the client no longer meets the requirements for an Intermediate Level of Care, the county office will be notified, and the ALF case will be closed. If the case is closed for any reason, the caseworker will determine if the client is eligible in any other Medicaid category. If eligible in another category, the recipient can be certified in that category without requiring a new application.

If the ALF Waiver client loses eligibility for one month only, the case may remain open with an overpayment submitted for the month of ineligibility. When the county has advance knowledge of ineligibility in a future month, procedures at MS 3341#1 will be followed, advance notice given, and the case adjusted on the system at the appropriate time. In both instances, a copy of the advance notice must be submitted to the DHS RN the same day the notice is mailed to the client.

If the ALF recipient will be ineligible for more than one month, the case will be closed and a new application will be required to reopen. If closure was due to a reason other than medical necessity, a new DHS-704 will not be required at reapplication if all of the following conditions are met:

- The case is being reopened within 2 months of the closure date.
- The DHS-704 was signed within six months prior to the new application date.
- The DHS RN was notified of the closure within 3 days of the action.
- The DHS RN was notified of the reopening within 3 days of the action taken.

If all of the conditions above are not met, a new DHS-704 will be required to reopen the ALF Waiver case.

An ALF Waiver recipient may appeal an adverse decision made on his/her case as outlined in Section 9300 of the Medical Services Policy manual. If the client chooses, the ALF case may remain open until the appeal decision is rendered. Services may continue if agreed upon by the client, the facility and DHS RN. When the caseworker

learns that request for an appeal has been submitted on an ALF case, the caseworker will notify the DHS RN immediately.

If at any time the county office finds the recipient ineligible for the ALF program, the DHS RN will be notified immediately and the county office caseworker will begin the process of closing the case.

26255 Temporary Absences from the Assisted Living Facility 01-01-03

Once an ALF Waiver application has been approved, waiver services must be provided in the facility for eligibility to continue. The county office will be notified by the DHS RN when waiver services are discontinued, and action will be initiated by the county office to close the waiver case with the following exceptions:

- Hospitalization

  When an ALF recipient enters a hospital, the county office will not be notified, and no action will be necessary unless the recipient does not return to the ALF within 20 days. If the recipient does not return from the hospital within 20 days, dies during hospitalization, is discharged to his home or elsewhere from the hospital, the facility will report to the county on Form DCO-702 and the caseworker will initiate case closure. If the recipient reenters another facility after discharge from the hospital, or if the individual is reassessed and no longer meets the Intermediate Level of Care, the facility will also report to the county on Form DCO-702, and the caseworker will take appropriate action.

- Nursing Facility Admission

  When an ALF recipient enters a nursing facility and it is anticipated that the stay will be less than 20 days, the case will remain open if the client does not request vendor payment for the temporary stay. If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 must be obtained and registered, and a new DHS-704 obtained. If all eligibility requirements are met, eligibility for vendor payment will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor payment may still be authorized because ALF recipients are considered institutionalized for Medicaid purposes, and the waiver eligibility prior to the facility stay may be applied toward the 30 day institutionalization requirement.

  If the individual does not return to the ALF, but stays in the nursing facility and requests LTC services, the Medicaid case may be left open while processing the registered LTC application. If found eligible for vendor payment, the vendor payments will be authorized beginning the date of entry to the nursing facility.

If found NOT eligible for vendor, or if after 20 days in a facility the individual does not apply for vendor payment, appropriate notice will be given for case closure.

- Absence From the Assisted Living Center - Non-Institutionalization

  When an ALF recipient is absent from the facility for reasons other than institutionalization, the county office will not be notified unless the recipient does not return within 20 days. If the recipient has not returned to the facility after 20 days, and the providers can no longer deliver services as prescribed by the Plan of Care (e.g. the recipient has left the state and the return date is unknown), the DHS RN will notify the county office to close the ALF waiver case.